

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 18 1959

59-028629

Registration District No. 114 Primary Registration District No. 4186 Registrar's No. 23

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>FRANKLIN</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>MISSOURI</u> b. COUNTY <u>FRANKLIN</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>SULLIVAN</u>			Length of stay in 1b <u>MINUTES</u>		c. CITY OR TOWN <u>SULLIVAN</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SULLIVAN CLINIC</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>215 E. VINE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA KAUSS RICE</u>				4. DATE OF DEATH Month Day Year <u>AUG. 11 1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 11, 1959</u>	9. AGE (last birthday) —		IF UNDER 1 YEAR Months Days Hours Min. — — — 30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INFANT</u>		11. BIRTHPLACE (City and state or country) <u>SULLIVAN, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>RALPH RICE</u>			13b. MOTHER'S MAIDEN NAME <u>PAULINE GRAHAM</u>			14. NAME OF HUSBAND OR WIFE <u>NONE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>RALPH RICE SULLIVAN, MO.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity - 6 months pregnancy</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>Aug 11</u> to <u>Aug 11-59</u> and last saw her <u>her</u> alive on <u>Aug 11-1959</u> Death occurred <u>2:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Robert M. Sampson</u> (Degree or title)				22b. ADDRESS <u>Sullivan, Mo.</u>		22c. DATE SIGNED <u>Aug 12-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>AUG. 12, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. MEMORIAL CEM. SULLIVAN MO</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR <u>H. M. L. Sullivan, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Aug. 16-59</u>		26. REGISTRAR'S SIGNATURE <u>Thomas A. Sampson</u>	

DED DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

~~or by~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Harrison M. Eaton

Licensed Embalmer No. 4192

P. O. Address Sullivan, N.Y.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above: